ADAP ADDITIONAL 30-DAY MEDICATION REQUEST FORM

PATIENT NAME (Last, First, MI):	**REQUEST DATE:**
D.O.B (MM/DD/YY):	**SEX:** ☐ **MALE** ☐ **FEMALE**
PATIENT TELEPHONE NUMBER:	
MEDICATION (S) REQUESTED:	**QUANTITY:**
IS CLIENT AN ACTIVE ADAP CLIENT? ☐ **YES** ☐ **NO**	**REASON FOR REQUEST:**
PROVIDER NAME:	**PHONE NUMBER:** **FAX:**
LOCAL HD ADAP CONTACT PERSON:	**PHONE NUMBER:** **FAX:**
FORM COMPLETED BY (NAME):	**PHONE NUMBER:**

MOST RECENT VIRAL LOAD RESULTS	DATE	MOST RECENT CD4 COUNT RESULTS	DATE

LAST ADAP ELIGIBILITY DATE:

ADAP USE ONLY

☐ **Request Approved** ☐ **Request Denied**

Notes:_____

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Signature:_____ **Date:**_____

Fax to CENTRAL ADAP office, ADAP Coordinator at (804) 864-8050

FORM UPDATED: 10/2017